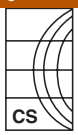
View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by Heidelberger Dokumentenserver



Article

Current Sociology Monograph
2020, Vol. 68(4) 572–591
© The Author(s) 2020
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/0011392120907642
journals.sagepub.com/home/csi
SAGE

Informal learning in formal organizations: The case of volunteer learning in the hospital

Kathia Serrano Velarde
Max-Weber-Institute of Sociology, Heidelberg University, Germany

Abstract

The sociology of education has much to gain from an organizational perspective on learning processes. This is especially true for 'informal learning' – that is, learning beyond traditional educational settings such as schools and universities. The present article addresses this gap by providing a theoretical and empirical account of the informality of learning situations in formal organizations. Following the insights of the 'situated learning' literature and interaction-based analysis, the article investigates the role and place of informal learners in formal organizations by analysing the learning experience of volunteers who have chosen to take part in the German national voluntary service. The author grasps the complexity of their learning experience over time by using a mixed methods design that combines ethnographic protocols with a series of narrative interviews with German voluntary service participants in hospitals. Since the volunteers observed in the hospital context were constrained to routine tasks that do not require medical skills, their scope of learning new things is indeed limited. Learning thus comes with the necessity of challenging the boundaries of their volunteer role, which in turn requires the cooperation of the regular staff. The article reveals the social mechanisms underlying the individual learning experience of hospital volunteers. It does so by focusing on their boundary work and by identifying the limits of their participation in the communities of practice that they are 'trying to help'.

Keywords

Boundary work, hospital, informal learning, learning in organizations, lifelong learning, rule breaking, situated learning, volunteer, helping

Corresponding author:
Kathia Serrano Velarde, Max-Weber-Institute of Sociology, Heidelberg University, Bergheimer Str. 58, Heidelberg, 69115, Germany.
Email: kathia.serrano@mwi.uni-heidelberg.de

Introduction

The sociology of education has much to gain from an organizational perspective on learning processes. Whereas most sociological research dealing with issues of education emphasizes the importance of classroom, cohorts, or educational districts in the making and unmaking of educational trajectories, relatively little is known about organizational effects on individual learning strategies.[1] This is especially true for 'informal learning', which is classically defined as learning beyond educational settings such as schools and universities (Allmendinger et al., 2011; Blossfeld et al., 2011; Werquin, 2010). The present article addresses this gap by providing a theoretical and empirical account of the informality of learning situations in formal organizations, i.e. 'specific units, purposively constructed to attain explicitly formulated goals and established with explicit authority structures and roles' (Blau and Scott, 1963: 5).

More specifically, we explore the phenomenon of informal learning by showing how individual learning interacts with formal and informal features of the organized learning environment. We therefore examine the informal learning experiences of volunteers in a hospital setting. Since hospitals do not primarily aim for their voluntary workforce to learn, we start with the assumption that volunteers must actively mobilize their resources to carve out a space in the organization where they can realize their individual learning objectives. This type of learning must be considered 'informal' insofar as hospitals do not formally account for the learning intentions of volunteers. We grasped the complexity of the volunteers' learning experience by using two types of qualitative data sets: first, we sampled narrative interviews with German voluntary service participants in hospitals. The interviews elicit narratives regarding the expectation framework of volunteers, learning situations in the host organization, and their contact with the wider organizational context. We paid particular attention to the changing nature of the volunteers' job-specific knowledge, of relationships with colleagues and of work tasks over time. Second, we 'shadowed' (Czarniawska, 2007) the volunteers for a period of four days in order to complement their subjective awareness of the learning context with systematic insights into learning-related interactions witnessed *in situ*. While presenting the findings of an explorative case study, this article develops new insights into the social mechanisms underlying the individual learning experience of hospital volunteers. It does so by focusing on their boundary work and by identifying the limits of their participation in the communities of practice that they are 'trying to help'.

Formal and informal learning at the hospital

Strauss's work on hospitals as 'negotiated orders' has spurred a new understanding of medical work (Strauss et al., 1963). Looking behind the curtains of formal hierarchy and bureaucracy at the hospital, grounded theory research emphasizes, instead, the steady stream of day-to-day interaction as the main reason that things get 'done' (Strauss, 1985). In conjunction with a heightened interest in occupational struggles for autonomy and dominance (Freidson, 1988), this has led to a loss of sociological interest in the formal order of the hospital (Currie et al., 2012). The following review will discuss sociologically informed research that has dealt with learning and learners in the hospital context.

Particular attention will be paid to the formal/informal divide in the production of knowledge boundaries between and across occupational groups. We conclude this section by providing a brief outline of the interdisciplinary research on volunteer learning before turning to the theoretical framework of the study.

Since Howard Becker's seminal study *Boys in White* (Becker, 1977), sociologists have been aware that the hospital represents a learning environment for medical occupations. In contrast to the classic curriculum they are confronted with during their first years at the university, medical students learn to contextualize academic knowledge and refine medical standards in interaction with hospital patients, staff and faculty during their clinical education. While studies have corroborated Becker's original thesis through insights into the professional socialization of different occupational strands and specialties (Bucher and Strauss, 1961; see also Bjørk et al., 2013; Maben et al., 2006), the bulk of contemporary sociological work understands hospitals primarily as contested ground for a variety of professional groups (Goodrick and Reay, 2009; Salhani and Coulter, 2009). The focus of this research is much less on learning than it is on the maintenance of occupational identities and boundaries in a rapidly changing organizational environment (Reich, 2016; Scott, 2000). In their ethnographic study of anaesthetic teams in British hospitals, for instance, Goodwin and colleagues (Goodwin et al., 2005) show that access to new knowledge through informal learning is strongly regulated in order to reaffirm the occupational boundaries and to support the customary distribution of practices in the organization. Insofar as they are the training ground for medical occupations, hospitals are organizations that feature a formal role and place for learners. Scholarly work has looked extensively into the way medical occupations produce and reproduce both knowledge and knowledge boundaries in the hospital (Barley, 1986; Barrett et al., 2012).

Thus it comes as no surprise that recent work on organizational change in hospitals stresses the importance of 'boundary work' (Lamont and Molnár, 2002) for the implementation of practical and technological innovation (Nicolini et al., 2016). Nicolini's study (2010) on the introduction of telemedicine in health care organizations, for instance, emphasizes the relational dimension of change and learning: telemedicine is a technologically induced new practice where doctors, nurses and patients learn to collaborate in order to construct the means of medical monitoring without co-presence. Ensuring the correct and systematic measurement of biomedical data by the patient at home, anticipating factors that might cause the disruption of the medical and social interaction, as well as creating a situation of 'normalcy' that gives the patient the impression of having real-time access to competent medical care – these challenges are the object of day-to-day (re)negotiation between medical staff and patients. Much in the same vein, Kellogg's comparative analysis on the implementation of the 80-hour workweek in two US hospitals shows that relational 'free spaces' – i.e. areas of isolation, interaction and inclusion – give 'reformers' in different work positions a forum for building a 'sense of efficacy' in accomplishing a routine change that challenges status boundaries in the hospital (Kellogg, 2014). Kellogg's findings are confirmed by Bucher and Langley (2016), who observe that 'free spaces' in the hospital allow for the reconfiguration of occupational work boundaries and interaction routines through 'reflection' and 'experimentation'. Drawing on social movement theory, these authors argue that micro-institutional change may occur in the hospital context as a result of social learning across occupational

boundaries. By isolating them from the defenders of the status quo, 'free spaces' enable reformers in different positions to interact apart from daily work routines, to self-organize and thereby develop a clear oppositional identity.

Sociologically inspired work has thus created awareness for the formal and informal dimensions of learning in the hospital. However, learning is either formally constrained to a professional socialization within distinct occupational groups, or it takes place within the 'folds' of the organization (Clegg et al., 2005) and across the occupational boundaries of qualified medical personnel. This being said, we know little about the way marginal groups such as volunteers embrace the hospital as a unique learning environment.

Interdisciplinary research on volunteering has linked volunteering with the development of civic skills (Putnam, 1995; Verba et al., 1995), job-specific hard skills and soft skills such as 'teamwork' and 'communication' (Duguid et al., 2013b; Slootjes and Kampen, 2017). Nevertheless, empirical evidence for competence building is scarce and mixed where the labour market output of volunteer learning is concerned (Paine et al., 2013; Rego et al., 2016).[2] Few research groups, such as the Canadian research network 'Work and Lifelong Learning in the New Economy' (Duguid et al., 2013a), have looked into the processual dimension of volunteer learning and its embeddedness in organizations. In the hospital context, volunteers are not formally considered 'learners'. They have no formal role structure to support and organize their learning activities. The learning aspirations of volunteers are thus relegated to the realm of the 'informal' (Van Maanen and Schein, 1979) and we have yet to understand how these people navigate the occupationally 'segmented' terrain of the hospital (Currie et al., 2012) to learn something for themselves.

Informal learning as boundary work

A fruitful avenue to the analysis of volunteer learning in the hospital context can be found in the concept of 'situated' or 'social learning' (Brown and Duguid, 1991; Lave and Wenger, 1991), which originated in the interdisciplinary field of education studies and subsequently spread into organization and work studies. Taking a clear stance against the dominant view of learning as a cognitive process through which individuals accumulate symbolic knowledge in organizations (Byrans and Smith, 2000; Choi and Jacobs, 2011), 'situated learning' focuses on the relational, interactive side of learning and knowing (Gherardi, 2000; Gherardi et al., 1998; Orlikowski, 2002). Situated learning occurs as individuals become members of communities through which they participate in the reproduction and transformation of sociocultural practices (Lave, 1991). The path of individual learners is thereby contingent on a number of features of their learning environment: first, learning is a conscious effort, on behalf of the individual, to actively 'engage with various tools, language and role definitions and other explicit artefacts as well as implicit relations, tacit conventions and underlying assumptions and values' of their work environment (Handley et al., 2006: 645). People will not learn by accident but because they intend to learn and invest resources for that purpose. Second, learning depends on 'legitimate peripheral participation' (Lave and Wenger, 1991). When newcomers enter a community of practice such as an occupational group, they usually do so from the periphery. They are given, for instance, only partial access to information and

practice-relevant tasks. Over time, new members are gradually exposed to all dimensions of the sociocultural practice until becoming competent. At this stage, newcomers have not only learned how to do things, they have also learned to read the local context in ways that are recognized and valued by other members of the community. In doing so, they gradually move from the periphery of participation to full participation (Handley et al., 2006). Third, and most importantly, these communities are (to a large extent) embedded in organizational settings and therefore intrinsically linked to knowledge production and reproduction in organizations (Gherardi, 2000; Nicolini, 2011).

While literature on situated learning has greatly enriched our understanding of meaning-making and identity-building in organizations, few studies have addressed how power dynamics structure both individual and collective learning in occupational communities (Contu, 2014; Contu and Willmott, 2003; Roberts, 2006). We propose to address this gap by exploring the boundaries of 'legitimate peripheral participation' experienced by volunteers in the hospital context (Handley et al., 2006). Evidence suggests that short placements (Warne et al., 2010) and the lack of meaningful supportive relations and tutoring (Konrad and Browning, 2012) may impede effective participation in a community's activities. The volunteers we observed in the hospital are experiencing these type of problems. They hinder the volunteers' learning ambitions by propelling them to the 'margins' (Wenger, 1998) of activity. However contested their legitimate participation may be, we contend that volunteers in hospitals learn something too. We therefore propose to understand informal learning as the conscious effort of volunteers to realize their individual learning objectives in the highly segmented learning environment of hospitals (Currie et al., 2012) through access to community-based resources.

Following the insights of organizational role theory, we refine our understanding of the 'boundary work' (Lamont and Molnár, 2002) of informal learners by assuming that hospital volunteers learn two things: for one, they learn to anticipate and fulfil the expectations of their surroundings in order to (re)produce reliable interaction routines (Bechky, 2006; Becker, 1986; Van Maanen and Schein, 1979). Volunteers thus learn about their formal role as 'helpers' (Haski-Leventhal and Bargal, 2008). In addition, volunteers learn to transcend the boundaries of their formal role by creating a space for the realization of their individual learning objectives (Ashforth et al., 2000; Berger, 1990). They do so by mobilizing available resources, negotiating access to participate in new community tasks, and finding ways to rise above those limitations that hinder individual learning progress. Thus, we define boundary work in Nippert's terms, as 'the strategies, principles, and practices that we use to create, maintain and modify cultural categories' (Nippert-Eng, 1996: 7). In the empirical part of this study, we investigate the volunteers' constant effort to break out of their formal role as 'helpers' in order to learn something new.

Data and method

The empirical study deals with the learning experiences of volunteers enrolled in the German 'state voluntary service' (*Bundesfreiwilligendienst*). Voluntary services have a long tradition in German civil society. However, this particular service, set up in 2011, is unique in that it is being financed and managed by the federal state. Approximately 100,000 people commit to this type of service every year.[3] Like most other voluntary

services in Germany, the 'state voluntary service' matches volunteers to host institutions in the social sector for a period of 6 to 12 months. During this time, volunteers work full-time and receive a small living allowance of about 400 Euros as well as a number of benefits. What makes this programme so relevant to our research question is its legal nature. By law, voluntary service programmes must 'further the educational competence of youths and represent a special form of civic engagement' (BGBI. I: 842). Although the federal state does not explicitly set out the type of 'educational competence' referred to in the text, volunteers are legally framed as 'learners'. The legal circumstance of their engagement contrasts with the individual learning experience in the host organization. Volunteers tend to have a 'liminal' status in their host organizations (Garsten, 1999): while the length of their work contract makes it possible to put them to work, it is not long enough to invest in some type of professional training. The voluntary status makes it particularly difficult to apply the means of negative or even positive sanction in the context of work. In addition, most volunteers have no prior working experience in the field they choose and tend to be seen as perfectly incompetent. When volunteers are sent to host institutions in the social sector, they face a highly professionalized and formalized organizational setting – that is, the authority structure tends to mirror occupational boundaries within the organization, and decision-making centrally revolves around highly trained professionals who demand control of their own work (Mintzberg, 1979). Due to their liminal status in host organizations and their lack of professional skills, volunteers thus tend to be assigned to simple routine tasks after a very short training period, and they stick to these tasks until the end of their service. Yet the volunteers we interviewed insisted that they chose to commit to a year of service in order to learn something new. Since the role of the 'volunteer' does not include a formal 'learning' dimension at the organizational level, we need to ask how volunteers manage to enact their learning aspirations in the host organization.

The article draws on a qualitative case study combining two data sets: 20 narrative interviews with volunteers in their fourth and fifth month of engagement and ethnographic protocols in the hospital context.[4] The present analysis focuses on the volunteer's learning perspective as developed in the framework of the narrative interviews. Following the premises of theoretical sampling, we began to do narrative interviews with volunteers who chose to work in hospitals. Of our 20 narrative interviews, the greater part were carried out in one of the largest university hospital complexes in Germany.[5] The hospital is especially renowned for the treatment of cancer and has a 65,000 in-patient capacity. It is composed of over 40 medical departments with about 10,000 employees, including 1700 professors and doctors. The hospital first started to work with volunteers in 2007. Since then, the number of volunteers has increased up to 120 per year. Our interviewees were mostly placed with the nursing staff in the radiology, endocrinology, cardiology, gastroenterology and oncology departments. Volunteers were generally assigned to assist the nurses, although volunteers working in the radiology and the angiology teams also interacted with technicians and doctors. We approached our interviewees to recruit them for our study during one of their early training seminars.[6]

The interviews focused on the experiences of volunteers in their first months of service. We were interested in uncovering what these volunteers managed to learn and how they went about it. The interviews thus elicit narratives regarding the learning biography

of volunteers, their expectations regarding the voluntary service, typical learning situations in the host organization, and their interaction with the regular staff. The interviews lasted between 45 and 180 minutes and were held at their workplace. We transcribed the interviews in full and anonymized them. In line with our explorative approach, we analyzed the material using a qualitative content analysis anchored in a grounded theory perspective (Denzin, 2000; Strauss and Corbin, 1998). A first round of open coding was conducted with the goal of identifying prevalent themes in all interviews. We noted strong similarities between volunteers with regard to the relational dimension of their learning experience. A second round of axial coding refined, related and interconnected the categories from the first round until no new subthemes or relationships could be found. We thereby developed more theoretical themes, producing conceptual categories such as 'role performance', 'role investment', 'boundary work' and 'rule breaking'. We then developed tables and charts to represent and compare data across volunteering experiences. A third and final round of coding focused on this select subset of codes and patterns to develop a coherent explanatory concept which we showcase in the discussion section of this article (Charmaz, 2014).

In a second step, we complemented the insights of the narrative interviews with an ethnographic field study carried out in the framework of a student project. Here, we used the shadowing technique (Czarniawska, 2007), following six volunteers working in the hospital for a period of four days each and taking detailed notes on the ways in which volunteers interacted with the regular staff and the patients. The ethnographic protocols were discussed and analysed in a student group setting. The students and the author read the protocols iteratively, compared their experiences and discussed possible sensitizing concepts. Although few students reported having witnessed a 'learning situation', the observations yielded important information on how regular staff and volunteers interacted on a daily basis. We used the insights gained from these observations to compare and control the subjective view of the narratives with the interactive reality observed *in situ*.

The findings section is structured around the main explanatory concepts we identified in our analysis. Because the learning narrative we encountered in the hospital is tightly linked to the biography of the learner/volunteer, we chose to include some biographical insights in the presentation of the data.

Findings

Our findings highlight two important dimensions of informal learning in the hospital context. We first show how the creation of learning opportunities hinges on the readiness of volunteers to invest in their role as 'helpers'. In channelling their resources into the community, 'informal' learners trigger their co-workers into giving up their time to show them something new. They are capable of creating learning opportunities within the highly formalized hospital setting because they engage in extensive boundary work. Second, informal learning may also lead to instances of rule breaking in the sense that volunteers and the regular staff engage in formally (and informally) sanctioned activities. To the extent that *ex post* legitimation of these training episodes is uncertain, this type of informal learning clearly indicates the limits of legitimate peripheral participation in the hospital context.

Investing in the role as 'helper'

When asked what they are actually doing at work, volunteers will typically answer that they are 'trying to help'. However banal such a statement may seem in the context of volunteering (Haski-Leventhal and Bargal, 2008; Wilson and Musick, 1997), the wording actually suggests two things. On the one hand, it alludes to the possibility of failure: volunteers intend to help but may fail to do so. This tolerance for failure, we argue, is a constitutive part of their social role as volunteers. Indeed, 'asking questions' is a recurrent if not pervasive communicative feature in volunteers' day-to-day work. As medically incompetent members of the organization, volunteers are required to ask for permission when doing something outside of their strict routine; likewise, they are required to voice their insecurities pre-emptively to avoid situations that might endanger the patients' wellbeing. On the other hand, the act of helping implies that volunteers have to anticipate situations in which their help is needed. Adequately performing the role of a volunteer does not simply mean fulfilling routine tasks according to the expectations of others. Rather, volunteers need to know what their co-workers are supposed to do in order to determine when and how to step in. The capacity to adequately determine a helping-situation is an acquired competence that comes with the possibility of legitimately refusing to help. Indeed, volunteers are mindful that they represent an asset to the community and allocate their help selectively, according to merit or social bonding.

While their status in host organizations thus seems constraining at first glance, volunteers are equipped with a number of resources that the nursing staff do not share. Volunteers generally have more time to do things than the regular staff. More specifically, volunteers are surprisingly free in the way they allocate their working time in the hospital. Volunteers who wish to learn something new will tend to mobilize these time resources in order to funnel them back into their role, thereby creating learning opportunities. Indeed, investing in the role of the volunteer is of paramount importance to the realization of individual learning objectives in the hospital. If informal learning in the hospital requires a conscious effort on behalf of volunteers to carve out a time and place for the realization of their learning ambitions, it can only be done with the active support of co-workers. Since the regular staff has the ability to provide explanations, to introduce volunteers to new work tasks, and to train them to perform these tasks adequately, volunteers must somehow marshal their support. They do so by investing the only resource they are allowed to manage for themselves: their working time. Volunteers who successfully enlarged their scope of action within their first months of service highlight the importance of accepting the work tasks that were assigned to them: 'I never said no, I don't want to do this' (Ekatarina, oncology). Another interviewee mentioned that he wants 'people to notice that [he's] putting in a lot of effort into what [he does]; that [he tries] to do it right' (Tobias, cardiac recovery room). During fieldwork, we observed that volunteers were constantly on their feet, using their spare time to ask about patients' wellbeing, check if their colleagues needed help, or empty the dishwasher in the common room. Interviewees pointed out that 'staying busy' (Tobias, cardiac recovery room) was not only a matter of adhering to the work culture in the hospital, but showing others that you were willing to take on more than your share was considered a personal investment that would be reciprocated if need be.

Learning as boundary work

Probing the boundaries of the volunteer role. Informal learning in the hospital is contingent on the willingness of co-workers to provide volunteers with the means to break out of their routine tasks. It also requires a conscious effort on behalf of the volunteers to signal their willingness to learn something new. Again, volunteers use the means provided by their social role to do this: for instance, volunteers frame their intention to learn 'the cool stuff' (Eva, gastro-intensive care unit) as an act of helping and thus constantly probe the readiness of their colleagues to hand over their more interesting work tasks. Karin's learning experiences in the cardiology ward make a compelling case for this type of signalling. Karin entered into the voluntary service because she did not know what she wanted to do after finishing school. Her vague interest in the medical field led her to pursue a volunteering position at the university hospital. When asked about autonomy at work, she responded:

> *I try to make this one thing very clear: I want to do as much as possible and I want to take on responsibilities.* The problem is that my colleagues fear that I am going to do something stupid and it's always unclear whether I am actually allowed to do something or not. So when someone says 'I have to do this and that,' *I always jump in to say, 'I can do that.'* They either say, 'yes, do it' or 'I'd rather do it myself,' and I accept that. (Karin, cardiology)

Karin actively shapes her role as volunteer by finding ways to incorporate new activities into her work repertoire. She thereby takes advantage of the legal grey zone where volunteer work in hospitals seems to fall. Since formal rules are often unclear with regard to the rights and duties of volunteers, the formal division of work may be breached at the discretion of the regular staff (see also Strauss et al., 1963). We will see that this type of rule breaking will not necessarily lead to an increase in the participation of volunteers in the community's activity. Yet, contesting the boundaries of volunteer work by probing the willingness of co-workers to show her something new constitutes a conscious effort on Karin's part to align her work experience with her learning intentions.

Finding time and places to learn. Informal learning requires not only a readiness to challenge existing work arrangements, it is also a matter of timing. Understanding when and where to draw on the limited resources of nurses, technical staff or even doctors is of paramount importance to the creation of learning opportunities. We illustrate this point by providing evidence from Daniel's learning biography. Daniel is a volunteer in the radiology department and in charge of preparing both the patients and the room for diagnostic X-rays. Since the preparation consists in a number of small steps, Daniel works with checklists that he has fashioned for himself and which he reads through every now and then. The medical staff with whom he interacts on a regular basis has noticed his accuracy. Since then, some of the radiologists allow Daniel to assist in more complicated interventions. When asked what he would like to experience over the following few months, Daniel responded:

> There is this one operation, in which the tumour gets grilled by microwaves. You get in through a tube and then you place the needle. I've never had the opportunity to witness one of those

> before. Well, I could never stand in the operating room – I watched it from the outside, from behind the window. There is so much going on in there. There are the students, and so many doctors. The radiologist has to be there too, as well as the anaesthetist. Well, the block is so full, I'd basically just be in the way. And with this complicated a procedure, *I'd rather not be in the way.* (Daniel, radiology)

Since volunteers are free to roam around the organization, it is not unusual for them to move to other wards, helping fellow volunteers or watching surgical operations. Daniel's statement reveals that he would like to be part of the operating team – he wishes to be present in the operating room, assisting the radiologist and writing down extensive notes to memorize what he has seen. Nevertheless, he also mentions that there is no place for him in the block and that he would most likely 'be in the way'. This display of caution is interesting insofar as numerous studies have described the operating block as a learning environment (Becker, 1977; Collin et al., 2011). Indeed, the presence of medical students indicates that there is a formal place for learners in operating situations, yet Daniel does not feel that he has the right to be part of this learning event, that entering the crowded operating block would defy his original mission, which consists in helping others. This image of Daniel standing at the operating window, ready to jump in if the opportunity presents itself, is rather emblematic of the type of learning we observed in hospitals. Because there is no formal acknowledgement of their learning intentions, volunteers who wish to learn something new must hover, probe, wait, and be ready to take advantage of learning opportunities when they present themselves. This also means that volunteers have to be mindful of the right time and place to learn. For instance, our interviewees perceived medical urgencies as important learning events. Nevertheless, none of them reported having taken an active part in one. Generally speaking, volunteers will wait for calmer periods in the ward to enrol their co-workers in their learning activities.

In the first part of this analysis, we have shown that volunteer learning at the hospital relies on important boundary work. Volunteers are capable of engaging with the medical community by investing heavily in their role as helpers, signalling their readiness to learn and waiting for the right time to probe existing work arrangements. Contesting the boundaries of one's marginal role and the established division of labour may come with the possibility of engaging with truly medical work at the hospital. Although participation in medical activities is strongly regulated by the community, we encountered a number of cases where these rules were breached, collectively or individually, to create learning opportunities for volunteers.

Learning and rule breaking

Eva's learning experience at the gastro-intensive care unit makes a compelling case for collective forms of rule breaking involved in volunteer learning at the hospital. Eva recently completed her schooling and applied for a volunteer position at the university hospital because she originally planned to study medicine. Although her stepmother has a medical practice and has coached Eva since secondary school, her first day at the gastro-intensive care unit came as a shock. Confronted with a terminal patient she had to care for, Eva began to question her career plans. Despite her doubts and uneasiness

around the bodily waste of patients, Eva tries hard to make it work: 'When I went home [after the first day at work], I started to wonder whether medicine is the right path for me. But I wanted to study medicine for so long that I did not accept this setback – that I'd simply stop, I mean' (Eva, gastro-intensive care unit). The nursing staff kept a close watch on Eva's efforts to come to terms with her tasks. After a while, some of the nurses started to include her in non-routine tasks, thereby widening the repertoire of activities Eva was allowed to perform. Eva commented on this development in the following way:

> It really is a matter of *not telling the head nurse right away.* But I don't have any problems with keeping things to myself. We got a list from the head nurse of the things we can do. The central venous catheter is listed there, among others. It's when you place a catheter into a patient's vein, into the artery. You can draw blood through the catheter without sticking a needle into the patient's arm and we are allowed to draw blood from the catheter and then inject it into a machine that gives us the lab results straight away. *This is something that [volunteers] are not normally allowed to do. But the head nurse agreed to this.* Other stuff such as placing the catheter, for instance, we are not allowed to do. Well, we cannot do it by ourselves – you need two people to do the job: one person pulls and the other assists by handing the cannula and the scissors. . . . In this case, we are only allowed to assist, but some colleagues allow me to pull the catheter myself, and that is pretty cool. Though *I'm not sure if the head nurse ought to know this* (laughs). (Eva, gastro-intensive care unit)

We consider this type of rule breaking to be collective in the sense that qualified nurses allowed Eva to take an active part in the catheter insertion procedure, an item that was excluded from the head nurse's list of volunteer tasks. The bilateral training agreement between Eva and 'some colleagues' remains tacit, however, insofar as they do not 'tell the head nurse straight away'. While in some instances nurses decide to train volunteers to perform non-routine tasks until they are considered competent and capable of executing them on a daily basis (such as in Karin's case), Eva expressed insecurities regarding the catheter insertion procedure. Indeed, German medical practice is restrictive concerning the application of central venous catheters. It is, for instance, not included in the three-year education of nurses and requires additional training. While it may be safe to assume that Eva felt she learned something new by taking part in the insertion procedure, this type of learning episode cannot be considered a legitimate form of peripheral participation. With the exception of the few nurses taking part in this illicit form of training, the community is unaware of it and unlikely to acknowledge the act of learning *ex post facto* due to tight medical regulations.

The circumstances of rule breaking become even more precarious where the act of learning does not involve co-workers. Because it represents an extreme case of learning through rule breaking at the hospital, we propose to discuss the one instance of individual rule breaking we encountered in our interviews: the case of Desirée who volunteered in the gastroenterology ward.

Desirée used to be strongly committed to her volunteer work and future career prospects in the medical field until reaching a tipping point in the fifth month of her service. She decided to quit volunteering after a period of particularly exhausting night shifts and accepted an internship in an investment firm instead. We met Desirée on her last day at

work. When asked if she thought that she had learned something useful during her time in the hospital, she responded:

> Yes, I learned a lot. At the beginning, I even took some of the patients' medical charts back home with me, even though it is not allowed. The medical charts list the patients with their diagnosis and all the medical examinations they went through. I took the charts with me so as to write down the medical vocabulary. I noted the medical term on one side and what it means and how it evolves or works and such on the other. And I learned a lot. *I think that I can express myself very well, medically, even though I am not a student of medicine*. (Desirée, gastroenterology)

Desirée's account is particularly detailed with regard to her learning strategies and objectives. Causal links are established between the daily routine of bringing home the patients' medical charts and her increasing level of medical literacy. She even provides some form of self-assessment, comparing her own level of expression to the expertise of medical students. While there is little doubt that we are dealing with a phenomenon of informal learning, the act of learning had not been shared with the staff. Desirée decided to take home the files even though she knew it was forbidden. Medical charts contain information on the patient's condition and are therefore important coordination devices for the hospital staff, who work in shifts. Taking these charts without informing her co-workers was thus an act that could have had serious repercussions on the wellbeing of the patients. This particular form of learning also constitutes an offence against the German law on data privacy to which all volunteers are sensitized in the first weeks of their training. Although Desirée learned something that enabled her to perform her role as volunteer and helper with more accuracy, she did so without the consent of her co-workers and by breaking the law.

The two episodes of rule breaking clearly highlight the limits of legitimate peripheral participation of marginal actors in the hospital. In both cases, the rules of work were breached without formal consent. While collective forms of rule breaking are rather recurrent in the hospital setting and are based on tacit, bilateral agreements between people involved in a given practice, Desirée's case is extreme and highlights the possibility that individual learning may take place outside of the community and as a form of deviant behaviour. Due to the highly professionalized nature of the communities of practice in the hospital setting, volunteer learning is highly constrained: the lack of training and the fact that they cannot legitimately claim a formal role as learners forbid volunteers from demanding participation in non-routine – especially medical – tasks. Learning through rule breaking is not systematic and bears little consequences for the reconfiguration of role boundaries. Nevertheless, it is important to point out that rule breaking is recurrent and volunteers learn something for themselves during these events, however marginal and socially precarious they may be.

Discussion

Volunteers refer to a broad range of competencies when describing their learning outcomes after a few months at the hospital. They mention that volunteering has furthered their personal growth, their social and communicative skills, or their professional knowledge. While the content of learning differs with regard to the learning biography of

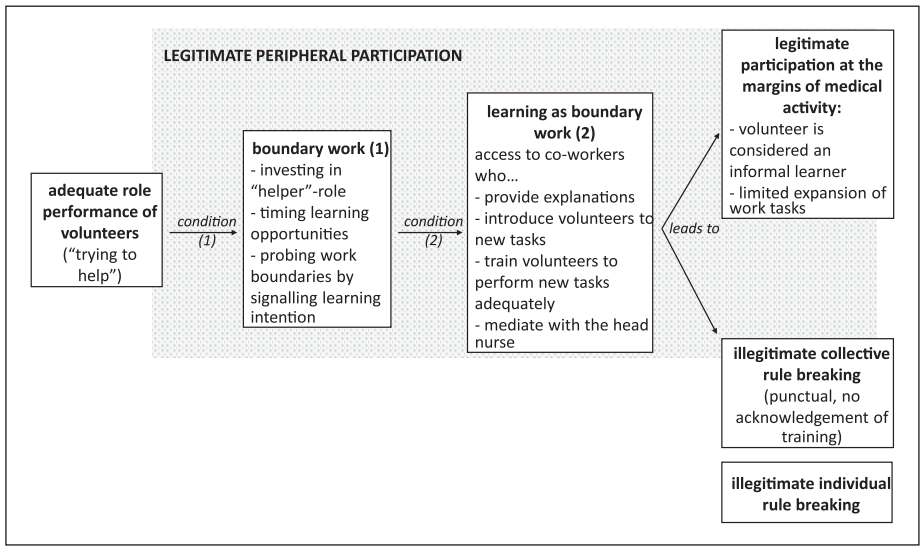


Figure 1. Informal learning and the boundaries of legitimate peripheral participation in the hospital.

volunteers, the mechanisms that enable them to learn something new are similar. Informal learning comes with the necessity to create learning opportunities in organizational settings that do not formally acknowledge or even support the learning aspirations of volunteers. Since the volunteers we observed in the hospital are constrained to routine tasks that do not require medical skills, their scope of learning new things is indeed limited. Learning thus comes with the necessity of challenging the boundaries of their volunteer role, which in turn requires the cooperation of the regular staff. Although we have witnessed informal learning strategies that do not build on the agreement of co-workers, most volunteers will attempt to marshal the support of their colleagues by investing in their role and 'helping out' whenever and wherever they can. By nudging their co-workers into reciprocating the act of helping, volunteers create informal learning opportunities that have the potential of widening their scope of tasks and increasing participation in the community's activities. Figure 1 depicts the different stages of boundary work required to create learning opportunities and raise awareness for the volunteer's learning intentions.

The power dimensions of social learning in the hospital become visible at two levels: first, volunteers find themselves in a power asymmetry insofar as they cannot formally claim that they are learners and draw on the community's time and knowledge resources. The formal division of hospital work as well as occupational boundaries restrain them to a position at the margins of activity. Secondly, legitimate peripheral participation through boundary work does not only require heavy investment in the volunteer's role as helper, but it is also restricted. Although the community of practice might, at some stage, informally acknowledge the learning intentions of volunteers, the possibility of legitimately widening their work tasks is indeed constrained by German medical law which is both detailed and strict. Engaging in medical care, the central activity of the communities we

observed, thus becomes a matter of rule breaking in the sense that training occurrences between regular medical staff and volunteers go unsanctioned by both formal hierarchy and the wider community. Although volunteers often mention these episodes of rule breaking as the most memorable and valuable learning experiences they had at the hospital, learning through rule breaking must be considered illegitimate and precarious in the sense that it is unlikely to encounter the community's approval and will not improve the volunteer's chances of participation. It follows that informal learning does not always serve the purpose of the organization (Ferdinand and Simm, 2007).

Conclusions

Although sociology has cultivated a rich debate on lifelong learning as a major policy dimension of the 'active' welfare state (Crouch et al., 1999; Powell and Snellman, 2004; Sennett, 2006; Valdés and Barley, 2016), little has been done to understand the social mechanisms underpinning learning outside of educational institutions. Attempts have been made to create longitudinal surveys (Allmendinger et al., 2011; Blossfeld et al., 2014), thereby enabling social scientists to grasp and explain the informal dimension of learning and how it affects/is affected by individual resources; yet theory-building efforts remain scarce (Kilpi-Jakonen et al., 2015). One reason for the reluctance of sociologists to embrace this promising field of study consists in the difficulty of grasping – both theoretically and empirically – the elusive 'informality' of learning events. We argue that an organizational perspective on individual learning trajectories might help researchers overcome this hurdle and develop a systematic understanding of informal learning as both an individually- and an organizationally-situated phenomenon. Our contribution shows that learning is contingent on the organized learning environment it is embedded in. Organizations provide different incentives for people to learn. Depending on their position within the organization, people will be confronted with more or less specific expectations about what they ought to learn. They will be provided with resources and knowledge to master these learning objectives. If, however, their individual learning intentions exceed those of the organization – as is the case with the volunteers we observed – we enter the vague terrain of informal learning in which boundary work and rule breaking open up possibilities for 'experimentation' and 'randonnée' (Clegg et al., 2005).

By highlighting the importance of boundary work and rule breaking for the realization of individual learning objectives in formal organizations, our explorative case study contributes to a critical understanding of power and learning in non-educational settings. More international comparative work is needed to test whether our findings can be replicated or even enriched through the analysis of other hospital sectors. The case study also sheds light on two further avenues for research.

First, future work on informal learning in organizations should address the interrelatedness of boundary work at different levels: intrapersonal (i.e. role switch and role change at the individual level, such as between the role of helper and learner), interpersonal (at the group or organizational level) and societal (Ashforth et al., 2011). Due to the limited scope of our data, we were unable to look into how these dimensions of boundary work co-evolve during the period of engagement. How does, for instance, the individual learning biography affect the way volunteers engage with new learning environments? To what extent

does the organization adjust to the learning strategies of volunteers? To what extent do societal norms about volunteering and learning play into volunteer learning? To answer these questions, we need more longitudinal work on learning biographies in organizational settings, covering both successful and unsuccessful learning strategies or 'exits'.

A second and related research avenue concerns the learning biography of individuals throughout different organizational settings and occupational positions. How do learning strategies – especially with regard to boundary work – build up over time and across different types of organizations? Our study showed that, in the hospital context, segmented role boundaries and knowledge-intensive work processes constrain the possibility of learners to (1) explore and experiment with tasks on their own and (2) participate more fully in the community's activities. Will informal learning in less professionalized organizations require a different type of boundary work? More specifically, how does the learning strategy of volunteers in the hospital context translate into later learning experiences in organizations?

Acknowledgements

I would like to thank my graduate students as well as Cornelia Maier-Gutheil and Frauke Mörike who have worked with me on the ethnographic part of the project. I thank Simon Bailey, Dean Pierides and the anonymous reviewers of *Current Sociology* for their insightful comments on earlier drafts of this article.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

ORCID iD


Kathia Serrano Velarde https://orcid.org/0000-0002-0306-7484

Notes

1. Notable exceptions are current ethnographic pieces that focus on the secondary socialization effects of educational institutions, such as Armstrong and Hamilton (2013), Binder et al. (2015) and Khan (2011).
2. Although both employees and employers believe in the positive effects of volunteering on the job market prospects of individuals (Kamerāde and Paine, 2014; Souto-Otero and Shields, 2016), it is difficult to disentangle the volunteering-effect from sociodemographic factors affecting job market placements.
3. It is important to note that state voluntary services have mushroomed across Europe over the last few years. France, for instance, has set up a programme (*service civique*) that enrols up to 300,000 young people a year. The German voluntary service (*Bundesfreiwilligendienst*) was introduced in 2011 after military conscription and the civilian service were suspended by the Ministry of Defence. In order to replace the substantial workforce of conscientious objectors in the social sector (and in the hospitals), the Federal Ministry of Family Affairs implemented a state voluntary programme: the *Bundesfreiwilligendienst* enrols up to 40,000 people a year. In addition, comparable volunteering programmes such as the *Freiwilliges Soziales Jahr* mobilize up to 60,000 volunteers per year.

4. The study is part of a larger research project that deals with voluntary work and learning in the framework of the *Bundesfreiwilligendienst*. In this context, we also conducted expert interviews with people in charge of implementing the service on both the national and the local level (Haß and Serrano Velarde, 2015). Although we used insights gathered from the expert interviews to inform our analysis on volunteer work in the hospital setting, we did not include the expert interviews in the analysis.
5. We chose to provide contrast to the findings in the hospital setting by interviewing a few volunteers in youth and refugee relief organizations. We tried to focus on variation regarding both hierarchical structure and the degree of professionalization. The comparison allowed us to refine our theoretical claims for the type of learning we identified in the hospital setting.
6. Although we tried to approach as many volunteers as possible, we believe that our data might entail a slight bias. The volunteers who agreed to the interview mostly saw themselves as learners and were quite eager to share their experiences with us. Thus, instances of failure, demotivation or exit remain scarce. As a result, we refrained from establishing typologies of learning strategies.

References

Allmendinger J, Kleinert C, Antoni M et al. (2011) Adult education and lifelong learning. *Zeitschrift für Erziehungswissenschaft* 14(2): 283–299.

Armstrong E and Hamilton L (2013) *Paying for the Party: How College Maintains Inequality*. Cambridge, MA: Harvard University Press.

Ashforth B, Kreiner G and Fugate M (2000) All in a day's work: Boundaries and micro role transitions. *The Academy of Management Review* 25(3): 472–491.

Ashforth B, Rogers K and Corley K (2011) Identity in organizations: Exploring cross-level dynamics. *Organization Science* 22(5): 1144–1156.

Barley S (1986) Technology as an occasion for structuring: Evidence from observations of CT scanners and the social order of radiology departments. *Administrative Science Quarterly* 31(1): 78–108.

Barrett M, Oborn E, Orlikowski W and Yates J (2012) Reconfiguring boundary relations: Robotic innovations in pharmacy work. *Organization Science* 23(5): 1448–1466.

Bechky B (2006) Gaffers, gofers, and grips: Role-based coordination in temporary organizations. *Organization Science* 17(1): 3–21.

Becker H (1977) *Boys in White: Student Culture in Medical School*. New Brunswick, NJ: Transaction Books.

Becker H (1986) *Doing Things Together: Selected Papers*. Evanston, IL: Northwestern University Press.

Berger P (1990) Sociological perspectives: Society as drama. In:Brisset D and Edgley C (eds) *Life as Theater: A Dramaturgical Sourcebook*. New York: Aldine de Gruyter.

Binder A, Davis D and Bloom N (2015) Career funneling: How elite students learn to define and desire 'prestigious' jobs. *Sociology of Education* 89(1): 20–39.

Bjørk IT, Tøien M and Sørensen AL (2013) Exploring informal learning among hospital nurses. *Journal of Workplace Learning* 25(7): 426–440.

Blau P and Scott W (1963) *Formal Organizations: A Comparative Approach*. London: Routledge & Kegan Paul.

Blossfeld H-P, von Maurice J and Schneider T (2011) The National Educational Panel Study. Need, main features, and research potential. *Zeitschrift für Erziehungswissenschaft* 14(2): 5–17.

Blossfeld P, Kilpi-Jakonen E, Vono de Vilhena D and Buchholz S (eds) (2014) *Adult Learning in Modern Societies: An International Comparison from a Life-course Perspective*. Cheltenham: Edward Elgar.

Brown JS and Duguid P (1991) Organizational learning and communities-of-practice: Toward a unified view of working, learning, and innovation. *Organization Science* 2(1): 40–57.

Bryans P and Smith R (2000) Beyond training: Reconceptualising learning at work. *Journal of Workplace Learning* 12(6): 228–235.

Bucher S and Langley A (2016) The interplay of reflective and experimental spaces in interrupting and reorienting routine dynamics. *Organization Science* 27(3): 594–613.

Bucher R and Strauss A (1961) Professions in process. *American Journal of Sociology* 66(4): 325–334.

Charmaz K (2014) *Constructing Grounded Theory*, 2nd edn. Los Angeles, London, New Delhi, Singapore, Washington, DC: Sage.

Choi W and Jacobs R (2011) Influences of formal learning, personal learning orientation, and supportive learning environment on informal learning. *Human Resource Development Quarterly* 22(3): 239–257.

Clegg S, Kornberger M and Rhodes C (2005) Learning/becoming/organizing. *Organization* 12(2): 147–167.

Collin K, Sintonen T, Paloniemi S and Auvinen T (2011) Work, power and learning in a risk filled occupation. *Management Learning* 42(3): 301–318.

Contu A (2014) On boundaries and difference: Communities of practice and power relations in creative work. *Management Learning* 45(3): 289–316.

Contu A and Willmott H (2003) Re-embedding situatedness: The importance of power relations in learning theory. *Organization Science* 14(3): 283–296.

Crouch C, Finegold D and Sako M (1999) *Are Skills the Answer? The Political Economy of Skill Creation in Advanced Industrial Countries*. Oxford: Oxford University Press.

Currie G, Dingwall R, Kitchener M and Waring J (2012) Let's dance: Organization studies, medical sociology and health policy. *Social Science & Medicine* 74(3): 273–280.

Czarniawska B (2007) *Shadowing and Other Techniques for Doing Fieldwork in Modern Societies*. Malmö: Liber.

Denzin N (2000) The practices and politics of interpretation. In:Denzin N and Lincoln Y (eds) *Handbook of Qualitative Research*. London: Sage, pp. 897–922.

Duguid F, Mündel K and Schugurensky D (eds) (2013a) *Volunteer Work, Informal Learning and Social Action*. Rotterdam: SensePublishers.

Duguid F, Mündel K and Schugurensky D (2013b) Volunteer work and informal learning: A conceptual discussion. In:Duguid F, Mündel K and Schugurensky D (eds) *Volunteer Work, Informal Learning and Social Action*. Rotterdam: SensePublishers, pp. 17–36.

Ferdinand J and Simm D (2007) Re-theorizing external learning: Insights from economic and industrial espionage. *Management Learning* 38(3): 297–317.

Freidson E (1988) *Profession of Medicine: A Study of the Sociology of Applied Knowledge*, reprint edn. Chicago: University of Chicago Press.

Garsten C (1999) Betwixt and between: Temporary employees as liminal subjects in flexible organizations. *Organization Studies* 20(4): 601–617.

Gherardi S (2000) Practice-based theorizing on learning and knowing in organizations. *Organization* 7(2) 211–223.

Gherardi S (2001) From organizational learning to practice-based knowing. *Human Relations* 54(1): 131–139.

Gherardi S, Nicolini D and Odella F (1998) Toward a social understanding of how people learn in organizations. *Management Learning* 29(3): 273–297.

Goodrick E and Reay T (2010) Florence Nightingale endures: Legitimizing a new professional role identity. *Journal of Management Studies* 47(1): 55–84.

Goodwin D, Pope C, Mort M and Smith A (2005) Access, boundaries and their effects: Legitimate participation in anaesthesia. *Sociology of Health & Illness* 27(6): 855–871.
Handley K, Sturdy A, Fincham R and Clark T (2006) Within and beyond communities of practice: Making sense of learning through participation, identity and practice. *Journal of Management Studies* 43(3): 641–653.
Haski-Leventhal D and Bargal D (2008) The volunteer stages and transitions model: Organizational socialization of volunteers. *Human Relations* 61(1): 67–102.
Haß R and Serrano Velarde K (2015) When doing good becomes a state affair: Voluntary service in Germany. *Voluntas* 26(5): 1718–1738.
Kamerāde D and Paine A (2014) Volunteering and employability: Implications for policy and practice. *Voluntary Sector Review* 5(2): 259–273.
Kellogg K (2014) Brokerage professions and implementing reform in an age of experts. *American Sociological Review* 79(5): 912–941.
Khan S (2011) *Privilege: The Making of an Adolescent Elite at St. Paul's School*. Princeton, NJ: Princeton University Press.
Kilpi-Jakonen E, Vono de Vilhena D and Blossfeld H-P (2015) Adult learning and social inequalities: Processes of equalisation or cumulative disadvantage? *International Review of Education* 61(4): 529–546.
Konrad S and Browning D (2012) Relational learning and interprofessional practice: Transforming health education for the 21st century. *Work* 41(3): 247–251.
Lamont M and Molnár V (2002) The study of boundaries in the social sciences. *Annual Review of Sociology* 28: 167–195.
Lave J (1991) Situating learning in communities of practice. In:Resnick L (ed.) *Perspectives on Socially Shared Cognition*. Washington, DC: American Psychological Association, pp. 63–82.
Lave J and Wenger E (1991) *Situated Learning: Legitimate Peripheral Participation*, 1st edn Cambridge: Cambridge University Press.
Maben J, Latter S and Clark J (2006) The theory-practice gap: Impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing* 55(4): 465–477.
Mintzberg H (1979) *The Structuring of Organizations: A Synthesis of the Research*. Englewood Cliffs, NJ: Prentice-Hall.
Nicolini D (2010) Medical innovation as a process of translation: A case from the field of telemedicine. *British Journal of Management* 21(4): 1011–1026.
Nicolini D (2011) Practice as the site of knowing: Insights from the field of telemedicine. *Organization Science* 22(3): 602–620.
Nicolini D, Scarbrough H and Gracheva J (2016) Communities of practice and situated learning in healthcare. In:Ferlie E, Montgomery K and Pedersen AR (eds) *The Oxford Handbook of Health Care Management*. Oxford and New York: Oxford University Press, pp. 255–279.
Nippert-Eng CE (1996) *Home and Work: Negotiating Boundaries through Everyday Life*. Chicago: University of Chicago Press.
Orlikowski W (2002) Knowing in practice: Enacting a collective capability in distributed organizing. *Organization Science* 13(3): 249–273.
Paine A, McKay S and Moro D (2013) Does volunteering improve employability? Insights from the British Household Panel Survey and beyond. *Voluntary Sector Review* 4(3): 355–376.
Powell W and Snellman K (2004) The knowledge economy. *Annual Review of Sociology* 30: 199–220.
Putnam R (1995) Bowling alone: America's declining social capital. *Journal of Democracy* 6(1): 65–78.
Rego R, Zózimo J, Correia M and Ross A (2016) Bridging volunteering and the labor market: A proposal of a soft skills matrix. *Voluntary Sector Review* 7(1): 89–99.

Reich A (2016) *Selling our Souls: The Commodification of Hospital Care in the United States*. Princeton, NJ: Princeton University Press.
Roberts J (2006) Limits to communities of practice. *Journal of Management Studies* 43(3): 623–639.
Salhani D and Coulter I (2009) The politics of interprofessional working and the struggle for professional autonomy in nursing. *Social Science & Medicine* 68(7): 1221–1228.
Scott R (2000) *Institutional Change and Healthcare Organizations: From Professional Dominance to Managed Care*. Chicago: University of Chicago Press.
Sennett R (2006) *The Culture of the New Capitalism*. New Haven, CT: Yale University Press.
Slootjes J and Kampen T (2017) 'Is my volunteer job not real work?' The experiences of migrant women with finding employment through volunteer work. *Voluntas* 28(5): 1900–1921.
Souto-Otero M and Shields R (2016) The investment model of volunteering in the EU-27 countries: Volunteering, skills development and employability. A multi-level analysis. *European Societies* 18(5): 487–513.
Strauss A (1985) Work and the division of labor. *The Sociological Quarterly* 26(1): 1–19.
Strauss A and Corbin J (1998) *Basic Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage.
Strauss A, Schatzman L, Ehrlich D et al. (1963) The hospital and its negotiated order. In:Friedson E (ed.) *The Hospital in Modern Society*. New York: Macmillan, pp. 147–169.
Valdés G and Barley S (2016) Be careful what you wish for. *Work and Occupations* 43(4): 466–501.
Van Maanen J and Schein E (1979) Toward a theory of organizational socialization. *Research in Organizational Behavior* 1: 209–264.
Verba S, Schlozman K and Brady H (1995) *Voice and Equality: Civic Voluntarism in American Politics*. Cambridge, MA: Harvard University Press.
Warne T, Johansson U-B, Papastavrou E et al. (2010) An exploration of the clinical learning experience of nursing students in nine European countries. *Nurse Education Today* 30: 809–815.
Wenger E (1998) *Communities of Practice: Learning, Meaning, and Identity*. Cambridge: Cambridge University Press.
Werquin P (2010) *Recognising Non-formal and Informal Learning: Outcomes, Policies and Practices*. Paris: OECD.
Wilson J and Musick M (1997) Who cares? Toward an integrated theory of volunteering. *American Sociological Review* 62: 694–713.

Author biography

Kathia Serrano Velarde is a Professor for Political Sociology at Heidelberg University. Her research focuses on the transformation processes in European education and research. She currently works on research projects dealing with new modes of financing and organizing research, practices of political consulting, and volunteering. Kathia is vice-president of Research Committee 17 ('Sociology of Organization') at the International Sociological Association.

Résumé

La sociologie de l'éducation a beaucoup à gagner d'un point de vue organisationnel sur les processus d'apprentissage. Cela est particulièrement vrai pour « l'apprentissage informel », c'est-à-dire l'apprentissage au-delà des cadres éducatifs traditionnels tels que les écoles et les universités. Le présent article comble cette lacune en fournissant un compte rendu théorique et empirique de l'informalité des situations d'apprentissage dans les organisations formelles. En suivant les idées de la littérature sur « l'apprentissage

situé » et l'analyse basée sur l'interaction, nous étudions le rôle et la place des apprenants informels dans les organisations formelles. Pour ce faire, nous analysons l'expérience d'apprentissage des volontaires qui ont choisi de participer au service volontaire national allemand. Nous saisissons la complexité de leur expérience d'apprentissage au fil du temps en utilisant une conception de méthodes mixtes qui combine des protocoles ethnographiques avec une série d'entretiens narratifs avec des participants allemands du service volontaire dans les hôpitaux. Étant donné que les volontaires que nous avons observés dans le contexte hospitalier étaient contraints à des tâches de routine qui ne nécessitent pas de compétences médicales, leur champ d'apprentissage de nouvelles choses est en effet limité. L'apprentissage s'accompagne donc de la nécessité de remettre en question les limites de leur rôle de bénévole, ce qui nécessite à son tour la coopération du personnel régulier. L'article révèle les mécanismes sociaux qui sous-tendent l'expérience d'apprentissage individuel des volontaires hospitaliers. Il le fait en se concentrant sur leur travail de délimitation et en identifiant les limites de leur participation aux communautés de pratique qu'ils « tentent d'aider ».

Mots-clés
Apprentissage dans les organisations, apprentissage informel, apprentissage situé, apprentissage tout au long de la vie, bénévole, enfreignant les règles, hôpital, travail aux frontières, aider

Resumen
La sociología de la educación tiene mucho que ganar desde una perspectiva organizativa sobre los procesos de aprendizaje. Esto es especialmente cierto para el 'aprendizaje informal', más allá de entornos educativos tradicionales como escuelas y universidades. Este artículo aborda esta brecha mediante un aporte teórico y empírico sobre la informalidad de los procesos de aprendizaje en organizaciones formales. Tomando ciertos conceptos de la literatura sobre 'aprendizaje situado' y el análisis interaccional, investigamos el papel y el lugar de la prendizaje informal en las organizaciones formales. Lo hacemos observando la experiencia de aprendizaje de los voluntarios que han elegido participar en el servicio nacional de voluntariado alemán. Estudiamos la complejidad de dicha experiencia a lo largo del tiempo mediante un diseño de métodos mixtos que combina protocolos etnográficos con una serie de entrevistas narrativas a voluntarios del servicio alemán en hospitales. Dado que a los voluntarios consultados solo se les permite desempeñar tareas rutinarias que no requieren habilidades médicas, su margen para aprender cosas nuevas es muy limitado. De ahí la necesidad de romper los límites de su función de voluntariado, lo que a su vez requiere la cooperación de los y las profesionales. El artículo revela los mecanismos sociales subyacentes a la experiencia de aprendizaje individual de los voluntarios del hospital. Lo hace centrándose en su *trabajo en límites* e identificando sus márgenes de participación en las comunidades de práctica a las que 'tratan de ayudar'.

Palabras clave
Aprendizaje informal, aprendizaje organizacional, aprendizaje permanente, aprendizaje situado, hospital, rompimiento de reglas, trabajo en límites (boundary work), voluntariado; ay